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National Council for Behavioral Health
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Grantee Virtual Meeting

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(Music Playing.)

>> Is there a portal for that or are you --

>> MALE SPEAKER: It's by email, the data collector sends it in by an email they provided. They talked about this.

>> MALE SPEAKER: So you saw this form and you have a PDF for the form?

>> MALE SPEAKER: For the data collection instrument?

>> MALE SPEAKER: For the RTHT.

>> MALE SPEAKER: We have a form we fill out and we have a study number that we match if they enroll.

>> MALE SPEAKER: You're emailing the RTHT form in to some email address.

>> MALE SPEAKER: Right.

>> MALE SPEAKER: Wow!

>> MALE SPEAKER: That's unexpected. Is that going to change? Is it always going to be like this for the length of this grant?

>> MALE SPEAKER: My understanding is we will be able to enter things online -- overlapping speakers.

>> MALE SPEAKER: Interesting.

>> MALE SPEAKER: Is anyone saving the RTHT information anywhere besides this form? Does anyone have an excess database or Google dock where you're storing this information and using it in some capacity?

>> BARBARA: This is Barbara from the Kodak project in Tucson and we're putting everything into our electronic medical record system so although not every single data point in the RHHT or in other things we are doing will go in there but test and screening results and other relevant information is going to be placed in the Next Gen electronic system above the screens and tools above and beyond what is required.

>> MALE SPEAKER: Great, when I gave them my examples I didn't mention EHR which is the likely place. Great have you looked at the information or just storing it right now?

>> BARBARA: No, I actually have developed a comprehensive data usage plan, and we don't have enough to look at it, yet, but we're using the game short screener, for example, and we're using other wellness measures and other things and they're all going to have a template inside of Next Gen and I will be able to export or the next person, Kodak will be able to export what I use depending on the size of the spreadsheet and I will produce reports back to them so we can share that with our leadership and stakeholders. So I will be doing repeated measures so I can use net measures by population.

>> MALE SPEAKER: Is that something you would share with the rest of the group?

>> BARBARA: Sure, I think I can give an overview via email that might make sense. If you don't know anything about the measures we're using, we're at the point where we're hiring a contractor in Next Gen because they're just starting their integration, they have just gotten that up and running so they're saying a deep, collective breath saying "yea, we have an HR" and we're saying, but we want to add these things for the grant and they're looking at us, like, really? So I can give you the structure and the plan, but I don't have that accomplished yet but I can give you the plan and show you what the graphs and everything will look like although all of the data will be fake.

>> MALE SPEAKER: Yeah, and that's good if not better because folks can fill in the blanks with what they believe their own data would look like and another way to frame the conversation that we're having and about to have is I want to encourage folks to get to the point where it sounds like you are at right now and seeing your example would be helpful for people who haven't gotten to that point yet. I'm curious from you all, do any or all of you have evaluation plans?

>> FEMALE SPEAKER: Yes.

>> MALE SPEAKER: Is that something you're hoping to put together? Couple of the people saying yes or no would be wonderful.

>> FEMALE SPEAKER: Yes, this is AWGF we have an evaluation plan, questionnaires from the clients' data that are extensive that we're having filled out with each of the clients but clinical data we have given --

>> FEMALE SPEAKER: Aaron?

>> FEMALE SPEAKER: -- to the aids partnership and to Henry Ford because although the AIDS partnership will share data specifically with us, Henry Ford is a big health system that had not always been great at sharing data so we have been developing ways to have them express some of the data for us so we can sit back and access the database and we're waiting for the potential to have the database.

>> AARON SURMA: Great, and get that go data from a large providing partner --

(Overlapping speakers.)

>> FEMALE SPEAKER: We worked with them before and the large providers are really difficult. We have dealt with them over the years with other projects and it's always difficult to come up with ways to do it so we went through their IRB with them and helped them with that to get permission and we have the clinical permission set up so there's always a bit of a process but I think everything is now working quite well now that we have spent time working with them and are getting some of the data back.

>> AARON SURMA: Great, thank you for sharing.

>> FEMALE SPEAKER: Hi --

(Overlapping speakers.)

>> AARON SURMA: Hannah, go ahead.

>> HANNAH: I e-mailed everyone the presentation and the conference number so continue on when you're ready.

>> AARON SURMA: If y'all could open up the slides we are day 1, breakout No. 2 and the session is called "Using Data to Improve Care" and we're going to talk about ways that --

>> FEMALE SPEAKER: Excuse me? I'm sorry, I didn't get that email. This is Barbara.

>> THE OPERATOR: This meeting is now being recorded.

>> AARON SURMA: Do you have Hannah's email address? If you could --

>> BARBARA: I just got it, thank you.

>> AARON SURMA: There we go, great.

(Overlapping speakers.)

(Overlapping speakers.)

>> AARON SURMA: Anyone who doesn't have the slides send an email to Hannah C. At the national --

>> FEMALE SPEAKER: That's too hard, come on now. HannahC@?

>> AARON SURMA: @thenationalcouncil.org.

>> FEMALE SPEAKER: Great, thank you.

>> AARON SURMA: And she will send slides back to you. For those of you who don't get them for another couple of minutes, don't worry, I will make sure everyone knows what numbered slide we are on so we can make this work out. For those of you who have them open, let's go to slide 2 and talk about the agenda. I want to talk about identifying the target audiences and I'm going to focus mostly on consumer level and project administrator level. I want to talk about conceptualizing the flow, you want to have a nice flow from the information you're collecting at the consumer level and let's say you're collecting age and gender right foot and racial identity, you want to know that at the consumer level, each clinician wants to know their case load, the break out of race, age, gender and at the administrator level you want to know race, age, and gender and of course you want to know much more than that, so I'm trying to give an example of whatever you are collecting at the ground level you want to look at in aggregate at the top and whatever you decide at the top level is important you want to make sure you're collecting it at the bottom level, so that's what I mean by the second agenda level and the third agenda level, the condition I couldn't say Quality Improvement Plan and I want this to be a discussion, and you all know where you are and I want to get you from wherever you are at to where you want to be and the most helpful way to do that is for you to let me know where you are and where you want to be on any given topic so be as vocal as you want to be. If you are speaking, unmute yourself, if you are not speaking mute yourself so we don't hear typing and stuff like that and most importantly, don't put us on hold, hang up and call back because if you put us on hold we hear your elevator music, and we have to bail out and it's a bummer so please don't put us on hold, just keep it muted if you want to step away for a few minutes. Let's go to slide 3 right now and these are the discussion questions I wanted to go over. Let's start with which step in your organization cares about project data. Are you at a point where it's just the project manager? Because they are responsible for this project? Are there any other people in your organization who care about this project? If so, who are they and what do they care about? What do

people in your organization care about with regard to this project? Go.

(Silence.)

>> CHRIS: I think that the People who are doing clinical treatment care about the data so -- particularly the questionnaire, stance abuse and mental health issues as well as the HIV questions to help them in dealing with the clients to make sure they are intervening if there is a crises that occurs over time. As an evaluator I'm interested in the data from an aggregate perspective and from the evaluation perspective, the head of our project who is the project manager, Nicola is interested in it to make sure everything is going well and from the -- to make sure that the clients are getting served.

>> AARON SURMA: Great, perfect answer. Anyone else?

>> PATRICIA: This is Patricia over in Milwaukee, we agree with everything she just said. We look at it as macro as well as micro clinicians like to know they're doing the best they can and the program likes to make sure they are giving the best services they have and they have developed the best program that they can so we can serve the community and the population and we use the data that we have as a program and a community center in order to press for changes in policy or in local governments and in state governments in order to best serve our population as a whole. So we go from bottom to top.

>> AARON SURMA: Great, wonderful answer, thank you. Anybody else?

>> BARBARA: I think we are all adding in a cumulative way, but we are looking at doing a repeated measure using the short screener so with regard to the behaviors that we are Targeting, we are trying to understand whether or not client risks are going down but in addition to that whether or not they're receiving services that were relevant to what their needs were when they came in. So if clients aren't receiving the services they need why aren't they and if people are not needing services did they get them, in other words, are they getting services they don't need and how are we giving things in a cost-effective way and when you look at those two things, we're

looking at that by our relevant populations, whether it's gender, race, ethnicity to understand whether or not there is any health disparities related to that lack of receiving services.

>> AARON SURMA: Great, helpful responses, thank all three of you for sharing. The other group I would like to point out is the GPOs, do the GPOs want to know whether you're complying with grant requirements and a lot of you talked about the different groups that want to hear about the data and what it says, clinicians want to know they are getting the data to know if their clients are getting better, all the way up to the administrative level and all of the levels in there, between, there is probably a need for collecting and managing requirements and there is also probably a need to collect some additional measures. I heard -- Barbara I can't remember which screen you use, daily living assessment.

>> BARBARA: (Away from mic.)

>> AARON SURMA:

(Overlapping speakers.) There we go, thank you. What else are you all collecting outside of the grant requirements that is helping to feed the data needs of all these different stakeholders?

>> PATRICIA: One of our internal evaluators at Chelsea would be happy to talk to you about the information we collect.

>> AARON SURMA: Thank you.

>> FEMALE SPEAKER: Yes, so we have -- we included some other forms of data collection instruments to capture other information so we have a family enrollment form where we capture what family members are helpful and supportive to the clients recovery, we have an HIV risk questionnaire that we asked our clients to see how they're -- how they have changed throughout their treatment and see if they're practicing safer practices at the end, as well as like an HIV knowledge questionnaire to see if they learned more about safe practices. Couple other forms that we have come together about just to get an overall data collection that we can share with our internal stakeholders and then we have a PSS scale which we use to measure posttraumatic stress symptoms that our clients have and we use that to

compare before and after treatment.

>> PATRICIA: Earlier I said that we are a family-based treatment program and we're situated within a community center so we collect data on not just our individual clients but also their family as a whole because we look to meet the needs of the family itself in order to make sure that everyone is as safe as they possibly can be so we collect our information from the family constellation, the history, the children's well-being, their safety, the drug use or lack thereof of everybody who is involved with the health and well-being of the children. The trauma histories of the clients as well as their extended family members. Their ability to meet their needs financially and physically with housing and food and clothing so we really run the gamut on information.

We tried to make sure we have as much as we possibly can in order to serve the clients with every possible piece they might need.

>> AARON SURMA: Great and that's an important extra stake holder group that I didn't bring up is families. So you're collecting additional information to make sure the families are informed that's wonderful, thank you for sharing that example. The whole thing I wanted to point out is there are grant requirements and you are collecting a lot of things and you should collect things that other stakeholders are interested in. Hopefully you have thought this true and Barbara offered up examples of evaluation plans that can be shared with all of you and I think there are folks who are trying to figure out what they can do with the data and you can see how other organizations conceptualize it. Now we're going to get through this presentation and I will show you examples from other projects that are not HIV specific but I think can be altered to cover the work that you all are doing. Flip over to slide No. 5 now.

>> FEMALE SPEAKER: Excuse me, should everyone have gotten the slides by now?

>> AARON SURMA: Yeah, Hannah sent them out at least once. If you could send her an email --

>> BARBARA: I've sent her two e-mails. Okay?

>> AARON SURMA: Hannah, hopefully you can send those to --

>> BARBARA: Okay, thank you.

>> HANNAH: What's your email address?

>> BARBARA: Sarnold@rrhs.org. Maybe I got your email address wrong.

>> HANNAH: Okay, thank you.

>> FEMALE SPEAKER: Hannah, if you're still there I also have not received them.

>> HANNAH: This is just a reminder, everybody can send me an email and I will forward those to you.

>> FEMALE SPEAKER: I did that.

>> BARBARA: I did that, too.

>> HANNAH: Okay.

>> FEMALE SPEAKER: Would you like for me to send it again? I did do that.

>> HANNAH: Yes, please, thank you, sorry about that.

>> AARON SURMA: Hopefully everyone will get their slides and if not please interrupt again and we will make sure we get them to you, we want everyone to be on the same page here, feel free to keep your phone lines open, let me know whenever you need something. We want this to be meaningful. Slide 5, this is where I wanted to talk a little bit about what external funders, board of directors and organizational administrators want to see and pictures, Mr. Burns, and I'm being dramatic about that, but I wanted to point out the cost savings is always on everyone's to do list and I think that's how you encourage partnerships between primary care providers, MCOs, Medicaid office with foundation and show that the services you provide save the entire system money in the long run and it might be saving money through reduced use of acute in-patient care or EHR visits, it might save money through reduced reliance on social services, there are many ways just like that -- I work on some projects where organizations show reduction in jail time as a result of their services. The local sheriff's office got behind it and petitioned the county to provide additional funding

because the sheriff's office saw that there was reduced amount of jail time with the people that were served. I don't know if that applies to you all but there are a lot of ways to think about cost savings and a lot of ways to show that you are achieving cost savings. I would like to plant that seed with everyone. Cost savings can be as in-depth as you acquiring a bunch of claims data, comparing the analysis with people who receive your services versus the two years previous when they received your services, that's a statistically sound method but you can always do simpler things, partner with a local hospital. Tell them whenever someone is in your ER, who is one of our consumers, call us, we will scoop them up and provide health services assuming it's not something drastic that really does require ER visits, so you are talking about reducing ER visits, they give you 100 calls a year, they know that saves them \$300 for each call they are grateful that you save them \$300,000, that's how you start talking about a partnership to promote increased care coordination so examples from a lot of organizations, from the most intense analysis of claims data down to anecdotal or semi-anecdotal from the amount of folks that are scooped up and brought back to the health provider. Folks want to see health improvement, are you improving the health of the community and government entities want to see that, foundations want to see that. You all want to know who sees that. If you go to slide 6 there is an example from the Missouri Health Homes Project, Missouri created health homes statewide and they have shared the outcomes of the health homes and right off the top they say these homes are saved \$31 million, fantastic, everyone knows saving money is good, everyone knows if you're in the tens of millions, that's a lot of money, a nice, straightforward way to show that your program is having a positive affect on one of the three aims of the -- which is reduction of cost and they achieved that by hospitalizations reductions, 9%, and that's -- that's the first stage of what they're trying to brag go, the next page they're showing that health improved and I don't think this example is perfect, I don't know what up 37% means, but I get the general idea that health is improving, I wish they would have labeled this differently but they're trying to convey that

health improved which led to a reduction in utilization of more expensive services which led to moneys saved. That's a nice example of sharing data that you are collecting from the services you are providing to external funders to your board as you try to make a case for why this service is important. And are any of you at the point where you are talking about cost savings?

>> BARBARA: In a different project I am working with some other folks and we are costing services, pre and post stance abuse treatment so we collect service utilization data when people come into treatment about hospitalizations, outpatient medical care, residential treatment, stance abuse treatment, mental health services, et cetera, so depending on how far you want to cast your net, right, so we know what people have done in terms of services because we ask them when they come in or it's already in their medical chart and we utilize national cost data, the cost of the ER visit, in-patient medical stay, et cetera, et cetera, and that's all published data --

>> AARON SURMA: Are you getting that from ARHQ?

>> BARBARA: I just e-mailed the person I'm working with, because I want to get the actual paper so I can send it to you and I can't think of what it is, it's a published cost study, I want to say it's by Michael French but I'm not sure. It's national data as of 2014, I think. So then we're trying to also understand once they come into our program what services did they receive according to their electronic health record and be able to talk about cost savings and what services we provided versus services others provided and their health positive outcomes in addition to the cost savings in terms of reduced service utilization.

>> AARON SURMA: And that's something everyone can do because you are all asking about cost savings and you will know amount of ER visits baseline, six months, 12 months, 18 months, 24 months and then you can apply that national cost data to those numbers and that's not perfect. By any means but it's a start. And you can show these to the local provider and talk about sharing information so you can more accurately look at these

numbers. It's a process and you build on it and you start with whatever is easily available to you and you make the information more in-depth as you go.

>> BARBARA: And the cool thing about what we're trying to do -- I love that you said it's not perfect but it's a place to start. Because with our electronic health record we don't know what we don't collect exactly, yet, so we're using the process of this grant to understand what data is important to collect and if we're able to get it off of the common data instrument for now and then use that data, and then we can begin to say we need to pull this from the electronic health record system and we can build on that so when this grant is over and we want to sustain this effort then all of the data elements that we need are built into our EHR and we can continue this process post grant.

>> FEMALE SPEAKER: Would you be willing to share the reference that you referred to before?

>> BARBARA: I certainly will. I'm -- I have an email into my colleague who is very intimately familiar with working with this cost data and as soon as he respond to my email I will send it out to Hannah or I will send it out to whoever you tell me to.

>> AARON SURMA: Thank you.
(Chuckles.)

go ahead.

>> FEMALE SPEAKER: I like the idea of sharing through Hannah, that's good, because my name is long and it's hard to get my email address right with that many vowels.

>> AARON SURMA: I assume if there is one person who is interested there are a number of people interested, so we will send out all resources that come up during this conversation to everyone who is attending this session.

>> BARBARA: Lovely.

>> AARON SURMA: Does anyone else have a story about presenting cost savings or health improvements on an aggregate level?

>> CHRIS: Yeah, we published some things some time ago because we did a

number of studies on -- intervention, drug and alcohol intervention in primary care and we did cost savings papers and one for adults under 65, one for adults over 65, and, so -- and we worked with Michael French on one of them. We have some experience in doing that kind of thing.

(Overlapping speakers.)

>> BARBARA: -- whether that's the cost data that I'm referring to, I can't remember. Do you use the cost data published by Dr. French?

>> CHRIS: We do some of it at various times. He was on the paper that we did some time ago on costs for alcohol intervention in primary care. But, yeah, I -- and we've done some things for one of our agencies here in Ann Arbor that deals with people who have serious and persistent mental illnesses and the CMH and looked at a number of cost issues with the clients and what could be done to save in terms of cost with this particular group, because there were some people who had very high utilization so we worked with them to figure out weighs not to do that, too. But I think the cost issues are really important. It can be hard to show numbers between differences of people but you can show trends which I think is the most important part of this.

>> AARON SURMA: Did you say Ann Arbor? Michigan?

>> CHRIS: Yeah. Our partner, AWBS were the evaluators for them, they are in Detroit.

>> AARON SURMA: Great, I'm in Ypsilanti right now, we're neighbors!

>> CHRIS: You are?

>> ASHLEY: Yes, I'm curious are you planning on doing a similar evaluation of this project at all?

>> CHRIS: Yes, certainly for ER visits that will be possible depending on what data we can get from Henry Ford in particular, and we know we can get data from AWBS on the clients, but we have to see what all as we're going along with Henry Ford -- it took them a number of months to get through their IRB.

>> AARON SURMA: Uh-huh.

>> CHRIS: And we wrote the thing for them to help them get through it.

It took us very little time to get through ours but -- that might be because we have more experience with it.

>> AARON SURMA: Right. And so it would be great -- y'all have a list serve for this project right? There is an MILICA list serve?

>> FEMALE SPEAKER: I know there is a National Council.

>> CHRIS: There probably is but I don't think we have used it?

>> AARON SURMA: I'm just thinking that in other projects that I work on, folks are normally open to sharing finished documents and I have a harder time convincing folks to share their planning documents or things that are in process. It would be great if you could share your cost analysis planning work whenever you get to that point with the rest of the group because I think that would be helpful for folks who are thinking about doing a cost analysis or starting to and spinning their wheels, seeing other folks' examples even if it's not a finished product, I think it's even more helpful if it's not a finished product so that would be great, we can be in touch after a year, whatever, that would be great to share with the group, if there is a list serve that would be a great start, hopefully we can share an email list or something like that.

>> FEMALE SPEAKER: That would be helpful if it was specific to evaluation because the National Council list serve and anything else that has a wider distribution is hundreds of e-mails and I don't know that I --

>> AARON SURMA: Too much.

(Chuckles.)

its way too much, I totally hear you.

>> FEMALE SPEAKER: Aaron, this is Gretchen and we have a community of practice which has a list serve so you are more than welcome to use that list serve.

>> FEMALE SPEAKER: How do we get to it? We can send that list serve to Hannah.

>> FEMALE SPEAKER: Thank you.

>> AARON SURMA: That would be great and --

>> GRETCHEN: I will have Hannah or Rose send you that information.

>> AARON SURMA: Thank you, kindly. Okay, so we're already more than halfway through our time and I haven't gotten to what I want to get to so let's move along now to slide 8. If you can go -- if you are following along at home and you want to actually go to play the slide show at slide 8 it will be helpful as we move on to slide 9 because there are animation prompts that you click through so on slide 8 if you get in full screen mode it will help move through slide 9 at the same pace. So I want to talk about sharing information at the program administration level. What do program administrators want to see? The list that I came up with from looking at some of your grant requirements include enrollment rates, I know you all committed to enrolling a certain amount of people, screening rates, screening, the goal of the screen -- the goal is to screen 100% of your enrollees, you want to know the prevalence of risk factors, how many people are screening positive, for HEPB, HIV, HEPC, you want to look at risk improvements, are you achieving vital suppression, if so, what are the medications, you want to be able to go down that rabbit hole and the way to start is by being able to pull up a list of people who have improved in your risk factors. Of course, grant requirements, are you complying with grant requirements? Are you doing IPPs like you're supposed to, reenrolling people -- whatever the -- are you filling out interviews at the assessments, 6 month, 12-month, 18-month assessments? All that stuff? So I wanted to show you what I have from another program, and then we will talk about what you do. I'm going to give you an example of a different integration program that I work on and it's about bringing primary care into the behavioral health setting and that's what I work the most on. This is an organization that had a hard time putting together reports, it was an external evaluator, putting together reports for the project administrator. The initial report she prepared was 17 pages long it was full of text and no one read it no one cared about it no one could make sense of it, it wasn't actionable. She got rid of the format, started from scratch and she said what's the most important thing that we're looking at and they wanted to start small so they just looked at enrollment rates. If you could advance the slide by hitting

the "right" key or whatever it is you have on your dashboard to go to the next slide, you will see that we just get the heading of a dashboard it says self and market mental health primary care clinic dashboard, January 12th, 2015 in the top left and if you hit "right" one more time you will see the total amount of people enrolled, 403 enrolled. They said great we have enrolled this many people, that good or bad? Let's dig into that more? You hit right again the next chart shows up that shows actual versus target enrollment. So you will see this line chart and their current enrollment is less than their target, their target was 467 when the report was pulled. They started small, asked questions and they put this in front of the entire team working on that grant. They said all right we're at 403, we want to get to 467, 457, I can't read that. Why aren't we at that now? What can we do to improve? The team brainstormed together, they said, we'll do interventions AB and C and we want to know additional information. Hit right again and you will see that the first piece of additional information they wanted is new patients from primary care. They thought they weren't getting enough referrals, so we need to get more referrals. We got 11 in the past month, our goal is 16. We think that is a key driver of what we really care about which is enrollment so enrollment is what we really care about but new primary care patients is a main driver of that enrollment so let's track that and brainstorm solutions for getting new primary care patients, how do we do that? Hit right again and we show an engagement rate and referral count so if you look at December, for example, 15 people were referred but only three actually showed up. They said all right here is the thing. We are getting people referred but no one is making it to the appointment. That is why enrollment isn't where we want it to be. Let's dig deeper into that. Hit right again, and let's look at the first appointments and they were as high as 45 for new clients. That's a huge barrier, completely explains why even though you referred 15 people, 15 people said yes it would be nice, only three made it because they're waiting 45 days, who knows what happens in people's lives in 45 days if them to attend, so we've got to get that number down and this is how they built

their dashboard. Now they're at a point where it's three pages, all filled with a similar amount of charts which is overwhelming at first blush but they were constructed based on the needs identified by the team reviewing the dashboard so it was amenable to the people who cared about this, right? They built it themselves, these are the numbers that we want to track, we understand these numbers and of course we understand these numbers because we asked to see these numbers. This is how they built their dashboard. I think you can click one more time and you will see completed versus cancelled, and the point I want to make is how they built this dashboard, they asked folks responsible for this grant, they have all clinicians involved, what are the most important metrics, how did you want to look at them, when are we going to look at them? They look at them monthly and then they set targets that everyone agrees on and they set time lines for when they should see movement in these metrics. So it might not be realistic to think you are going to change your referral process and see improvement immediately. Maybe it's, all right, we're going to implement this change, we don't expect to see progress for three months, great, we know to circle back in three months. If you want to hit right one more time, we're now going to the next slide, this is a bulletin board that they have in their meeting room and this is their referrals made. That's what they wanted to focus on. They have the goal, the actual amount of referrals made, they have it on the bulletin board, everyone can see it, this is what the staff said is the most important driver, this is in our control and this is what we want to work on. So everyone can see this and everyone knows about the amount of referrals. So I wanted to talk with you guys about this concept, what are you tracking on your project dashboard? Is what I have here an example? Something relevant to you? What are better examples? What do you all want to see auto a project dashboard? And I would like to hear from the project directors or evaluators speaking for the project directors, what is important to you? What did you want to see on a monthly or quarterly basis.

>> CHRIS: We certainly track the enrollment to date and how that compares to expected enrollment. We also -- expected enrollment and we

track admissions, and it depends on the audience at the time but just for our monthly study team meetings those are typical items that we include.

>> AARON SURMA: Is everyone on board with that information? Who is in the room and do they all care about it? That's my real question. Who is review it go? How invested are they in those numbers? Are you still there? Might you have muted yourself?

>> CHRIS: It really depends right exactly as you just said, who is in the room and what are we talking about at that time. The data that we bring forward for our study team, they let us all know how we're doing on the project to date, who is in, who is not in, how many admissions, how many assessments, how many follow-ups, whether or not we're meeting target numbers on the objectives, and what we can track to that point so they give us that processed data. Now in a managerial meeting or something that's more program focused we talk about how this particular project fits in or sits in the larger program as a whole and how that's impacting the services that we provide. So, for example, how the HIV education is sitting with the health education overall, what sort of tweaks and changes we flight need to make based on the population that we have, for men, women, and families. So, again, it depends on the audience.

>> AARON SURMA: Great. You know your audience, you know who cares about what. Anyone else have examples of what they're tracking?

>> FEMALE SPEAKER: Yeah, I think we're tracking all those things, too, and one of the things that we think about I agree with is we have to think about the audience that we're talking to at the time and we try to collect enough data in different areas that we can provide people with what they would be interested in but certainly the head of agencies are interested in something slightly different and having done some work with legislators, they are also interested in something totally different so we try to keep that in mind as we do it.

>> AARON SURMA: Thank you. Anyone else?

>> SARAH: I'm the evaluator from the project in Delaware and we have a meeting every month and look at intake, follow-up, and discharge, the amount

of positive or unsuccessful discharges, and we report on monthly graphics, because we have populations we are trying to reach and we look at outcomes ask that we are trying to achieve and move into a monthly report so we look at program improvements that are data driven so if we have a lot of people that are failing then we are looking at who are those people and why are they failing? We also do quality at this active studies so we do focus groups with participants and that gives us another perspective on that, not monthly, but. . .

>> AARON SURMA: Great, sounds like the folks who have chimed in so far have very well formulated ideas of how to use the data you're collecting, what it means, who needs to see it. Is anyone struggling with this? Anyone who hasn't started thinking this through yet?

>> CLAUDIA: Yes, I'm from the treatment center in New York New York.

>> AARON SURMA: Hi, Claudia.

>> CLAUDIA: Yes, we have had some problems because we couldn't start the grant because we were not able to open the building, we didn't have permission from the Department of Health to start serving patients in the primary care area so we started recently and we are going full force forward and we have 30 people that have signed up and 11 to 15 that have already gone through the whole process, and I don't have an evaluator yet so as of now I am tracking a lot of what everybody has said already, initial intakes, referrals, social worker referrals, primary care, how many stance abuse screens have we done, if the referrals are coming from outside sources or within Whitney Young, and that would be a general sense of what I'm tracking and we do have as well electronic medical records where it has not just the medical side but it also has a case management side of things so we're able to track demographic and how many people are coming back for care, how many people are not, if they're taking medication and that's where we are at.

>> AARON SURMA: Somebody who chimes in under we're not doing that much reporting, sounds like you have your feet under you nicely, for the time being. The sense that I'm beginning to get of this group is that you all are further along in your analysis of project data than the organizations

that I am used to working with in other settings are. That's good for me to know because y'all are stuck with me for the next three years as your data PA provider so good for me to get a sense of where you are right now. Thank you for sharing. And even though Claudia says still trying to get their feet under them around data, it sounds like you've got a lot going on but it would be great to share these dashboard examples that other folks have put together that when Claudia and other folks like Whitney Young are able to get an evaluator, that would be a great starting point so if anybody wants to share their dashboard with Hannah, that would be great and we can share that with the rest of the group in our follow-up breakout session. Thank you all for sharing. Let's see, going back to the slides now and looking at slide No. 12 and it's just another example of what could go on a dashboard but it sounds like you all are -- have put more thought into this than my chincy examples here so let's move on to slide 14. We're going to talk about reporting for consumers now and this is a slide with Lisa Simpson on it and generally in my experience folks want to see their health status, are they getting better? Where is their health status at right now and the treatment plans. The example that I'm going to show you on slide 15, we're at slide 15 now is from an organization that was bringing primary care into the behavioral health setting and they would print this off whenever the consumer comes in the door for any kind of appointment. The person comes in, checks into the front desk, front desk prints this off, pick it up and bring it with you to all of your interactions with any clinician on site. It could be with your Colin Cal therapist, your product support group, could be to get your blood drawn anything. You're bringing this around with you so you understand why you're there, the clinician understands why you're there, you see the treatment plan, goal, action steps on this group and you see your health status and you don't need to be a doctor to understand this health status because it's color-coded so you don't need to know if you're having a glucose of 115, fasting, it's not where you want it to be, so it's color-coded. This is an example of an individual wellness report for an integration project but now I want to go to slide 16 and talk with you all

and see what information are you sharing with the people who receive your services under this grant, and is it all part of your grant data collection? Are you having to augment it? Who looks at it? How you track progress, all that stuff. Who wants to talk first about individual wellness reports for consumers?

>> CHRIS: I think I can say that we don't do one like this. I know that AWBS talks to their clients about how things are going but I think this is a really nice idea. I would think we could develop something like this with some slightly different monitor issue but certainly -- because part of our silent tell are people with serious and persistent mental illnesses that are part of AWBS' group so when we have that group in particular and these issues when we have worked with them before have done things that have helped track four clients and certainly there are other things that they are working on that they wouldn't want to track and some of the medications that they're taking. So it's an interesting thought I'm going to share this idea.

>> AARON SURMA: Great. I know that these are prepared in a lot of different ways. Some organizations are able to be prepared straight out of their electronic health record. Some have to get a data dump into an excess database and that's where they are created. Folks that have to get -- most organizations that have tried to make these have been able to make something that was helpful. In my dream somewhat selfishly is to show up at a site visit one day because I go out to these organizations and see someone walking around with their health report laminated, I would adore that, that would be the coolest!

(Laughter.)

is anyone else preparing something like this? Does this create ideas? If so, what would you want to put on this as it relates to this project?

>> FEMALE SPEAKER: We were just discussing as she said being a behavioral health versus straight primary medicine we probably couldn't do quite this way because although it's great information I'm not actually necessarily impacting their blood pressure per se. But we were talking

about the factors that we would include on there, Chelsea, did you want to throw that out?

>> CHELSEA: We were thinking like usage in the last thirty days or as you mentioned before, ER visits and UCI, also from some of our other skills, maybe risk factors, such as unprotected sex with injection drug users, those type of things or from the PTSD symptoms list like nightmares or other symptoms.

>> FEMALE SPEAKER: Or maybe medication and we were thinking about healthcare in dentistry or whether or not they have engaged in medical appointments that would keep them in a healthier state of being without necessarily tracking the actual, physical condition. Maybe something like that.

>> AARON SURMA: Great, that's relevant to your population, thanks.

>> FEMALE SPEAKER: I have a thought, we have a portal for patients where they can go and see their stuff but a lot of the people that I'm working with, with regard to this particular grant have either mental health problems and they just won't access it, so right now what we are doing especially with those folks that are HIV positive is that we just give them a little -- like a little -- how would you call it, like a little booklet that states their account, when their next appointment is, if they have a mental health appointment, when it is and if they're taking their medication for hepatitis C when was the last dose, sort of give them a little bit of a detailed thing that they can look at and put in their wallet and that's what we're doing.

>> AARON SURMA: That sounds helpful and if you want to send that to Hannah, that would be wonderful to share with the rest of the group.

>> FEMALE SPEAKER: Sure.

>> AARON SURMA: Thank you.

>> BARBARA: I just wanted to let you know that I e-mailed Hannah the cost information so that should be coming to you.

>> AARON SURMA: Fantastic, this is coming together nice. You all are high achievers and hopefully we can share these resources and achieve even

more!

>> FEMALE SPEAKER: Hi, everyone, this is Joanna from EBCRP in Oakland. I like the idea of the wellness report, it's not something we are currently doing but I like the suggestions that people have made and also I wanted to add a thought for us because we're working with individuals in recovery, I was thinking it would be great to add how many groups they had attended or individual counselling sessions just as a way to keep encouraging them to come and to show you've been coming from this time pretty regular and to show the progress that they're making, I feel like that would be a good incentive for our clients because day-to-day it can feel so hard and they're grinding away but I think to track their own progress would be helpful.

>> AARON SURMA: I'm glad you brought that up. There is one organization -- and I will send this around. Hold on, writing this down. They have a task force and on each page they have a wellness group and each time you attend one of the groups you get a stamp on the appropriate page and once you get a certain amount of stamps you can cash it in for a price. 10 stamps is a water bottle, 20 stamps is -- and 50 stamps is a Subway gift certificate and that's what -- did and the wellness attendance went up because there is something about a stamp and a little pamphlet, something to track what you're doing, there is a score associated with it and people love that.

>> JOANNA: That's a great idea. We have been doing something similar in terms of giving people raffle ticket for reach group they attend and at the end of the week we draw it and we have been giving Subway gift cards but I love the idea of the passport, too, they go together so well, so great, thanks for the idea.

>> AARON SURMA: Thanks for the raffle idea, that's even easier to implement. Wonderful. Any other thoughts on any kind of reporting to the people they serve?

(Silence)

>> RICHARD: This is Richard Sherman we are doing the evaluation for the

new Age Grant in Chicago and the issue we have run into is the same one that a lot of people have run into and that's the CDP. We have done a lot of & son evaluations, mostly with grants, we have experience with the TRAK and the SAY systems, and we were largely dependent on, you know, entering our data into the SANSA web site, download it go into an SPFS file, running analyses, ran reports, PowerPoints that helped illustrate the demographics of the clients, the outcomes on an individual -- Gipra items and things like that which people found helpful. It's been very frustrating in this particular situation -- we have toyed with the thought of entering our own DCIs into the SPFS files and doing our own double data entry but we were getting the inkling that this is going to get better and maybe that was assumed and a lot of people are struck by what a step down in -- just technology and features the CDP was from what the SAIS was, and the TRAK system as well although we didn't have as much experience in that one, but I'm just venting here and I'm hoping that they come up with a solution fairly soon where we can, you know, get -- that will assist us in helping to make better use of our data and using it to generate the various types of reports that we have been talking about today.

>> AARON SURMA: And I agree, I've heard that from other grants that I work on as well that it's difficult to know how to manage not being able to access CDP when you don't know the timeline for when it will be back and hopefully it will be back soon now that they're dedicating more resources but it's tricky when you're in the dark and I think that a lot of folks might have developed alternate methods of storing data if they would have known there would be an entire year without being able to use the program. If any one of you have developed something, a secondary access database, anything else, that would be great to hear about.

>> RICHARD: We have done that with one grant, not this one but we did it with another grant I developed an SPFS system with the variables and the value labels and that type of thing and with some GPOs, not necessarily the one with this grant we asked them, are we exported to double data entry? No, no, no and what we heard today was that the CDP was not going to be up

anytime son, that's what we heard from the CMS folks and maybe there will be an interim solution I guess, but maybe we will rethink doing an SPFS database with this.

>> AARON SURMA: Right, right, it's tough to commit to that when you don't know the timeline.

>> CHRIS: I agree, I do think that data entry and having people to do the data entry and all of that is part of these kinds of projection and it's certainly challenging.

>> AARON SURMA: Uh-huh. Yeah, and it's tough to give you all advice because I don't know anything more than you do about when CDP will be available or what it will look like. I know that on the other project that I keep referring to, folks are waiting for the batch upload instruction for the client DCI as well as the code book before developing tools for electronically tracking results of those. They're in a funky spot, I hear you, and I wish there was something else I could tell you, and I don't think that the GPOs know anything other than what they have relayed, it sounds like everyone is kind of in the "unknown" about what CDP will be available and what it will look like once it's fully available. But, um -- go ahead.

>> BARBARA: I did not mean to interrupt, I'm sorry, I was just going to ask the group because I've asked this question before, and I haven't really gotten anywhere with it, and I was curious whether someone has asked the same question or received an answer. The instrument, I wanted to know the psychometric properties and references for the scales and induces that are created in the instrument and I have not received any documentation after asking for a very long time. Both for the origin instruments, the legacy instrument and for the new one and I didn't know if anybody knows the answer to that. I would like to be able to cite it and reference where these items are coming from and I'm not getting anywhere.

>> RICHARD: I remember going back to the Legacy GIPRA tool, they call it that because it doesn't have the psychometric properties that you are looking for, basically they plucked items from different scales, some of them from the severity index, some of them from the McKinney Homes tool and

it looks like that's what they've done with the DCI so I don't think it's anything that you would be able to see scale properties are or you're probably looking at, you know, doing comparisons on individual items that, sort of thing.

>> BARBARA: That was kind of what I had surmised over the years and I knew the Legacy tool fit into that category and it seemed like looking at the items where they might have come from and they were haphazardly put together and how the tool was modified over time, they just sort of added things together and didn't do it in a structured way but I was not sure if the tool had a better pedigree.

>> RICHARD: I think that's why they call it a tool and not a survey.

>> BARBARA: Okay, thanks, it's helpful to know there is someone else thinking about it besides me.

>> FEMALE SPEAKER: There is, but it's --

>> CHRIS: There is but that's the way it's been I think for a long time. So I think for them to do the validation of the psychometric properties, probably would take some time and be pretty expensive.

>> BARBARA: Sure, well I don't expect them to do it, I was just -- I was just --

>> CHRIS: I'm just saying that's probably why it isn't -- there isn't that!

>> BARBARA: Yeah, I was just kind of hoping that maybe there was a selection of standardized items that was taking into consideration in the development of the new tool, but I agree, I don't think that's the case.

>> CHRIS: I haven't seen that, but that would be a good thing.

>> BARBARA: Yeah.

>> AARON SURMA: And Mark Jacobson was one of the people speaking at 2:20 today and he was one of the people I asked about the survey and questions, I will send him an email and let you all know, and if the answer is different than -- there are different answers from other places but if the answer is different than anything we have talked about I'll let you all know.

>> BARBARA: Thanks, I appreciate that.

>> AARON SURMA: I'm making a note for myself and then I will start talking in a second. Okay, we have 5 minutes left, you all probably aren't dying to stay on this any longer than you have to so in the last 5 minutes, let me know, what would be helpful? What kind of data needs do you all have that we haven't discussed. What would you all like me to do, what did you want to hear about or learn from each other? What's up, basically.

(Silence)

>> FEMALE SPEAKER: If anybody has an access database that they have put together for collecting this stuff in the interim for -- until the CDP comes up, should it ever come up, that would be great to share along the way if we could. We're still of course stuck with no Spanish version of various pieces of things and that would be nice, too. But mostly it's those -- that smaller process collection that we're looking at now and we really did like this wellness piece and we're thinking about how we can come up with a report card, if you will, for our clients out of our EHR so if somebody has one going we don't like to reinvent the wheel if we don't have to. We would like to utilize what has been done and tweaked. So if somebody has something exciting, we would love to see it.

>> AARON SURMA: Hopefully we use the list serve to share those resources and I'm happy to act as the hub, you send it to me or Hannah and we send it out to everyone, I agree, share as much as possible, no reason for people to do things from scratch when it doesn't have to be done. I know in another project I'm working on somebody decided to bite the bullet and develop an electronic store house for DCI interviews, I can't remember what program she is using but once that's available I will send it out to you all as well. What else do you all need? What would be helpful?

(Silence)

>> AARON SURMA: Great, then it is 4:27. This is supposed to go to 4:30, I feel like we've done our job, so at this time hopefully it was helpful, like I've said a couple times, I don't know where you all are at, I have a much

better idea now than I did an hour and a half ago but you are going to fill out a survey tomorrow when this two-day shebang is completed and please write in whatever questions and needs you all have and I'll get back to you and provide whatever kind of technical assistance I can provide. Go ahead.

>> HANNAH: Before everyone leaves the line I just wanted to reiterate, send those documents to myself and I can forward them to Aaron but tomorrow we will begin again at 1, just use the same link that you used earlier today and I will have more instructions for you as far as the breakout sessions, if we're going to do it like this or if we can get Adobe working, until then, just email if you have questions.

>> FEMALE SPEAKER: Thank you.

>> FEMALE SPEAKER: Thank you.

>> AARON SURMA: I don't know if my email is on these slides but it's Aaron1@nationalcouncil.org and you can get it tomorrow, we'll be in touch, use Hannah has a hub, me as a hub. Thanks for your participation. Good day, everyone.

>> FEMALE SPEAKER: Thank you, bye.

(End of presentation.)

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